STATE HEALTH BENEFIT PLAN

TOBACCO CESSATION PROGRAM AFFIDAVIT FORM

KAISER PERMANENTE HMO MEMBERS

Policyholder/Plan Member Name_____

Social Security Number_____

I hereby certify that all covered members have not used any tobacco products in the last 60 days. In addition, I have attached a certificate of attendance in a Kaiser-SC program of six classes for each dependent who previously used tobacco.

I also understand that this document must be completed and returned to my payroll benefit coordinator in order for re-evaluation of the tobacco surcharge currently being applied to my health coverage premium. In addition, if I or any covered dependents resume using any tobacco products after attending these classes I will complete the necessary document to notify the Plan. I can submit a statement from a doctor that the member suffers from a medical condition that makes him or her unable to be tobacco-free for 60 days and wear a pedometer and enter daily steps into an online log at least 5 days every week. Any change will be effective relative to the payroll schedule for my employer. No refund in premium will be made for the previous deductions that included the surcharge amounts. IRS rules require all premium charges to be prospective.

Signature_____ Date_____

Note: Once you have read and sign this affidavit you must submit it to your payroll location/benefit coordinator to have the required deduction information completed below.

Department/School System Use Only		
Payroll Location #	***Date of first deduction**	**Deduction Amount**

***Retro deductions will <u>NOT</u> be granted.**